

Maricopa County Group Insurance Form

Department Use Only						Val	/alidation E					Effect	Effective Date of Coverage					
	Employee Information																	
(Please Print)																		
Request Alternative Identification # Last Name								First Na	First Name			MI	DOB	☐ Male ☐ Female		Ma Sin	rried ale	
Yes No																		
□ Social Security # (must provide) Mailing Address								City	City					Zip Code				
Home Phone Work Phone & or Pager N							lumbor	Limber Email Address						Assigned Dept.		<u> </u>	HRMS	
11011	ne i none	,			WORK I HOHE & OF	Nork Phone & or Pager Number				Email Address				Assigned Dept.	[MIHS	
							Reason For Form											
	New ☐ Add Dependent(s)						Remove Dep	endent(s)	ndent(s)			ment Cha	□ Beneficiary Change			nge		
	Hire		п				D. / (" .! . l .	6 II			01 60			□ Addres			<u> </u>	
	Name Change	☐ Bir	arriage th			Divorce(effective date Legal Separation	of divorce)			Either you or	ouse's employment our spouse switched from part-time vice versa. nange in your spouse's employer 's		□ Other C	hang	je			
_			_	loption of Child gal Guardianship of child			Death Dependent child reach	nes limiting age o		of				(can include information about self or				
		9-	Qı		al child support order		contract Other	5 -5		insui Othe		an.		dependent) Open Enrollment				
For	mer Nam	ne:			permit an employee to			ge under a gro	under a group health plan during a period of			iod of coverage	and make a new	→ Unpaid leave or FMLA				
election that corresponds with the special enrollment right provided under the IRC Section Code 125 regulations. It is the responsibility of the										Begin Date	eave gin Date							
	documentation of the qualifying event within 31 calendar days of a family status change. Retroactive changes may not be allowed unless otherwise required by law.										End Date Other							
			required	by law.			NΛ	odical	Dlane					Other				
Medical Plans																		
Includes Avesis Vision plan and Cigna Behavioral Health Care (CBH)																		
□ Health Select □ CIGNA □ Decline Medical																		
					☐ Prir	ne Op	tion [□ HMO			Prime (Plus	Option		e proof of other cov				
										r ius				must work a minimum of 60 hours per pay to qualify for waiver money).				
Level of Medical Coverage																		
	Add Employee ☐ Add Employe Delete Employee ☐ Delete Emplo						e and Spouse Add Employee and Children yee & Spouse Delete Employee & Children					Add Employee and Family Delete Employee & Family.						
			1					ental F	•						, -			
□ United Concordia □ Employers							s Dental Services (EDS)					Decline Dental						
					· · ·		Level o	f Denta	I Cov	/er	age							
	☐ Add Employee ☐ Add Employee and						and Spouse					☐ Add Employee and Family						
□										□ Delete Employee & Family								
	Co	oro	linatio	n of B	enefit Infor	matic	on Must provi	de informa	tion rega	ardir	ng other av	vailable (no	n employee Ma	aricopa County) c	overa	ge		
Medical Plan Name:							I.D. #		Group #		Plan Address		Effective Date					
Dental:Plan Name:																		
Employee & Dependent Coverage Information																		
Add Employee Last Name							First Name		DOB		Sex	Social Security #		Medical Provider #:				
	Add Spouse Last Name			ame	e First Name			DOB		Sex	Social Secu	urity #	EDS Dental Provider #: Medical Provider #:					
	Drop					rnacivanio						,	EDS Dental Provider #:					
	Add Child Last Nam			me		First Name		DOB		Sex	Social Security #		Medical Provider #:					
	Drop Student Last Nam												EDS Dental Provider #:					
	Add Child Last Nar			ame		First Name		DOB	DOB Sex		Social Security #		Medical Provider #:					
	☐ Drop ☐ Student ☐ Edist No.												EDS Dental Provider #:					
	Add Child Last Name					First Name		DOB	OB	Sex	Social Secu	urity #	Medical Provider #:					
	Drop		Student										EDS Dental Provider #:					

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Basic Life with AD&D 1 X Salary											
Unum Life (paid by Maricopa County)											
Supplemental Life with AD&D Unum Life											
(Paid by employee)											
Non-Smoker	Smoker										
□ 1 X Salary □ 2X Salary □ 3X Salary □ 4X Salary □ 5X Salary		□ 2X □ 3X □ 4X	C Salary C Salary C Salary C Salary C Salary	 Decline Supplemental Life 							
Life Insurance Beneficiary Information For Basic and Supplemental Life											
✓ Primary- The entire benefit goes to the person(s) listed as "primary"											
Examples of types of designations	 ✓ Secondary- In the event of the Primary beneficiary's death, the benefit would go to the person(s) listed as "secondary" ✓ Percentages- Must total 100% ✓ Do not list a dollar amount 										
Name	Mailing	Address	DOB	Phone Number		Relationship	Benefit Percentage				
Dependent Life Unum Life (Paid by employee) □ Spouse \$5,000 & each child \$2,500											
□ Spouse \$10,000 & each child \$5,000 □ Decline Dependent Life											
		Short Term Di	sability				-				
Unum (Paid by employee) □ 50% □ 60% □ 70%											
Decline Short Term Disability											
Once your plans go into effect, you must have a "Qualified Family Status Change" as defined by the IRC Section 125 in order to modify your Medical, Dental coverage or Spending Account plan Elections. Information about the IRC Section 125 plans can be found online at: http://ebc.maricopa.gov/hr/benefits/.											
I authorize payroll deductions(from my paycheck) for the required rates due for benefits I have chosen. I understand that these rates may be revised periodically.											
If there is a clerical error, the County will correct the administrative error on a no-loss, no gain basis between you and the County.											
I certify that I have read the following information and I elect to participate under the stated requirements.											
Employee's Signature : Date:											